7. *Bertillon System of Identification.*—A copy of the Bertillon card of Czolgosz with a few personal generalizations.

8. *Consciousness and Neural Action.*—A short essay touching on some material sides of this philosophic problem.

9. *Science and Christian Science.*—A vigorous exposé, now somewhat threadbare of the inconsistencies and money-making schemes of this latest development of pseudo-religious mania. CLARK.

Journal de Neurologie.

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1. Phenomenon of Charles Bell in Peripheral Facial Palsy. BOUCHAUD.
2. Traumatic Paraplegia. M. DE BUCK.
3. Contribution to the Localization of the Cervical Cord. PARHON AND GOLDSTEIN.
4. Case of Labyrinthine Vertigo Cured by Electricity. LIBOTTE.

1. *Bell's Palsy.*—In 1897 Bordier and Frenkel described in facial palsies of the peripheral type, a movement upward and slightly outward of the eyeball, on the affected side on attempting to close the eyelids. (Described by Charles Bell in 1823.) This was observed only when the reactions of degeneration were complete, absent when partial. Hence they assumed it possessed a certain prognostic value, as well as diagnostic, being absent in the cerebral type. It occurs normally, if while effort is made to close the lids, the upper is held open with the thumb, and according to Bordier in sleep, nausea, and syncope. Dr. Bouchaud's patient was a woman aged twenty-six years, with atrophy of the right lower extremity due to acute poliomyelitis in early life. She incurred a complete paralysis of the left side of the face from exposure to cold. Two months previously she had suffered with pain and tinnitus in the left ear, with slight deafness, which symptoms had disappeared before the advent of the paralysis. Six months later Bell's symptom was first sought. Instead of the eye-ball rolling upward and outward, it took its course downward and inward, more rarely downward and a little outward, the cornea disappearing beneath the lower lid. This peculiarity was present in the right eye as well. It persisted even after the disappearance of the palsy and the onset of the secondary contractions. Bordier attributes Bell's sign to a labyrinthian irritation. Campos ranks it with the consensual movements. Bouchaud offers no explanation for this reversal of the well-known phenomenon. It is interesting to note that the same deviation was noted in a case of advanced locomotor ataxia with no evidences of facial weakness.

2. *Traumatic Paraplegia.*—A field laborer, while lifting a heavy spadeful of earth, felt a sudden crack in the right hip with immediate pain and paralysis in the right leg. He could walk only by the use of a crutch and cane. The leg is held flexed, the foot is rotated outwards. The entire right leg became atrophic and flaccid, weak movements may be carried out. There was slight diminution of the pain and temperature sense of the entire right leg and in the sciatic distribution of the left. Sphincters were normal. There was pain and tenderness in the region of the right buttock and Pouparts ligament on the same side. Above the latter a tumor was palpable (extirpation later showed enlarged lymphatic glands). An X-ray of the pelvis was negative. Hip-joint was normal. An electrical examination showed a diminution in the response to both currents applied directly and indirectly on the right side and limited to the sciatic distribution on the

left. The knee-jerk was abolished on the left side and was exaggerated on the right side. Both Achilles jerks were absent. The man had a dorsal kyphoscoliosis the result of Pott's disease in his seventeenth year. Dr. De Buck thought that an injury to the right sacro-iliac joint implicating the lumbo-sacral plexus was the most rational diagnosis notwithstanding the bilateral involvement of the extremities.

3. *Contribution to the Localization of the Cervical Cord.*—The results, obtained by the authors, are based on a careful study of the anatomy of the cell groupings in the eight cervical and the first dorsal segments from a normal cord. A case of infiltrating carcinoma of the anterior thorax, axilla and arm, producing a lesion probably equivalent to a resection of the brachial plexus. Animal experiments were also employed. The authors felt justified in formulating the following conclusions. (1) The brachial plexus begins at the upper portion of the 4th cervical segment and terminates at the lower portion of the 1st dorsal segment; (2) the antero-internal group of cells does not enter into the formation of the plexus which supplies the muscles of the vertebral column; (3) the phrenic originates above the 4th cervical segment (confirming Dumond, who places it between the 3rd and 4th cervical; (4) the spinal accessory originates in the antero-external group in the 1st and 2nd cervical segments. Its longitudinal extent could not be determined; (5) the supra- and infraspinatus muscles are represented by the intermediary group in the 4th cervical segment; (6) the pectoralis major by the intermediate group in the 5th cervical; (7) the anterior brachial region by the posterior groupings in the 5th cervical; (8) the serratus magnus by the gitudinal extent could not be determined; (5) the supra—and infra-7th cervical probably supplies the pectoralis minor; (10) the triceps by the posterior groupings in the 7th cervical and the intermediate group in the 8th; (11) the postero-external group in the 8th cervical innervates the posterior surface of the forearm and the short adductor of the thumb; (12) the postero-internal group innervates the anterior region of the forearm; (13) lower in the 8th cervical the posterior and internal groups supply the muscles of the hand; (14) in the 1st dorsal the small lateral group innervates the hand muscles—the more anterior assist in supplying the anterior surface of forearm.

4. *Case of Labyrinthine Vertigo cured by Electricity.*—Patient, a woman aged twenty-nine years suffered from headaches and vertigo for several years. The vertigo increased in severity, became constant and was accompanied by a staggering gait, nausea and vomiting. There was constant tinnitus in the right ear with slight deafness. Acuity of vision was normal but any visual effort was accompanied by great fatigue (ascribed to disorder of accommodation—analogous to the double vision sometimes observed under similar conditions). Curettage of the pharynx, politerization, tympanic massage and finally incision of the membrana tympani had been practised without avail. The "l'aigrette statique" produced at first an amelioration and finally a cessation of symptoms which had existed three and one half years. J. R. HUNT.

MISCELLANY.

A FORM OF HEREDITARY CEREBELLAR ATAXIA. Thomas and Roux (Revue de Medicine, No. 9, September, 1901, p. 762).

The patient who forms the subject of this paper belongs to a family which, for two successive generations, have produced five individuals afflicted with the same disease. In all of them, the first symptoms have appeared at about the same time, and have followed the